Help-seeking preferences for psychological distress in primary care: effect of current mental state

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ABSTRACT

Background

There is much debate over when it is appropriate to intervene medically for psychological distress, and limited evidence on patients' perspectives about a broad range of possible treatment options. It is currently unclear whether preferences may differ for those patients with milder symptoms compared to those experiencing more severe distress.

Aim

To determine patient preferences for professional, informal, and alternative help for psychological distress in primary care, and the impact of their current mental state on these.

Design of study

Cross-sectional survey in seven general practices across suburban/urban London.

Method

Participants were 1357 consecutive general practice attenders aged 18 years and over. The main outcome measure was the General Health Questionnaire 12-item version and a questionnaire on help-seeking preferences.

Results

Overall, only 47% of participants reported wanting 'some help' if feeling stressed, worried, or low and it was affecting their daily life. Those currently experiencing mild-to-moderate distress preferred informal sources of help such as friends/family support, relaxation/yoga, exercise/sport, or massage along with general advice from their GP and talking therapies. Self-help (books/leaflets or computer/internet) was not popular at any level of distress, and less favoured by those with mild-to-moderate distress (odds ratio [OR] = 0.50; 95% confidence interval [CI] = 0.35 to 0.70). Those experiencing severe distress were much more likely to want talking therapies (OR = 3.43, 95% CI = 2.85 to 4.14), tablets (OR = 3.07, 95% CI = 2.00 to 4.71), and support groups (OR = 3.07, 95% CI = 1.72 to 5.47).

Conclusion

People with mild-to-moderate distress appear to prefer informal sources of help and those involving human contact, compared to medication or self-help. This has implications for the implementation of potential interventions for psychological distress in primary care.

Keywords

help seeking; mental disorders; primary health care; stress, psychological.

INTRODUCTION

There is debate about when GPs should medically intervene for psychological distress, given that the evidence base of many treatment options is sparse, especially for milder disorders.[1–3] Previous work suggests a large 'unmet' need for the treatment of psychological disorders,[4–6] with a suggested reallocation of resources from milder to more serious cases to decrease unmet need in more serious disorders.[4] Evidence from population surveys suggests that most people do not seek help for depression or anxiety.[7,8] Some studies have, however, suggested that most people actually identified with depression in primary care preferred active treatment with counselling or antidepressants to watchful waiting.[9–11] There is a need to establish if this applies in other populations, including those with milder disorders, and whether this view would be different if participants could choose from a broader range of options such as informal support, self-help, exercise, and complementary or alternative strategies. This is important information for managing patient need in the large number of

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patients attending with milder distress.

Past work has shown self-help strategies are commonly used in mild-to-moderate distress,[12] and likewise complementary or alternative therapies in people with self-defined 'anxiety attacks' and 'severe depression'.[13] Both studies were community surveys with low response rates. It is not known how distressed primary care attenders regard options such as informal help seeking, complementary therapies, and self-management approaches in direct comparison to more traditional forms of professional help. This study examined how the severity of their current level of psychological distress affected general practice attenders' help-seeking preferences.

How this fits in

There is much debate about the need for medical intervention for mild-to-moderate psychological distress in primary care, and a weak evidence base for interventions. Little is known about patient preferences across a range of informal and complementary as well as health-professional options. This study shows that patients with milder symptoms preferred informal sources of help and simple advice from their GP over more formal interventions. The severely distressed group showed stronger preferences for formal 'talking therapies' and were less likely to want to talk to family and friends, which supports current guidance for reserving these for more severe disorders.

METHOD

Study population and participants

The study was conducted in seven general practices in suburban or urban London, UK. Consecutive adults aged 18 years and over attending their GP or practice nurse during morning and afternoon sessions at different times of the week in each practice were invited to complete a waiting room questionnaire. Those unable to complete a written questionnaire in English were excluded.

Measurements

The questionnaire included the 12-item General Health Questionnaire (GHQ-12), a widely used and well-validated screening instrument for psychological distress in primary care,[14] and questions on help-seeking preferences. Participants were asked 'If you were feeling stressed, worried or low and it was affecting your daily life, would you "deal with it on your own", "like some help" or "not sure"'. All participants were then asked to select up to three preferred sources of help. These included professional sources (advice from GP or nurse, medication, counselling, psychology, or psychotherapy), and alternative sources (talking to family or friends, self-help leaflets or books, computer or internet-based self-help, massage or aromatherapy, homeopathic or herbal treatment, support groups, religious or spiritual support, relaxation exercises or yoga, and exercise, sport or hobbies).

Data analysis

Multivariable logistic regression was performed using Stata (version 8.0). Models were fitted adjusting for age and sex, and for clustering by GP practice using robust standard errors.

RESULTS

Sample characteristics

In total, 1383/1528 (91%) of the eligible patients approached had completed the questionnaire. A further 311 were approached but excluded as they were unable to complete a written questionnaire in English. Twenty-six participants were excluded due to incomplete data. In the sample 920 (69%) were women and the mean age was 41.6 years (standard deviation [SD] = 16.9, range 18–98 years). Using a 2/3 case threshold on the GHQ-12, 632/1357 (47%) were potentially psychologically distressed. Of these, 343/1357 (25%) scored 3–6 (mild-to-moderate distress) and 289/1357 (21%) scored 7 or more (severe distress).

Help-seeking preferences

Overall, 552/1326 (41.6%) stated that they would choose to 'deal with it on their own' if they were feeling stressed, worried, or low and it was affecting their daily life; while 621 (46.8%) would 'like some help'; and 153 (11.5%) were 'unsure'. Those with current mild-to-moderate distress (adjusted odds ratio [OR] = 1.27, 95% confidence interval [CI] = 1.08 to 1.50) and severe distress (adjusted OR = 1.78, 95% CI = 1.40 to 2.28) were more likely to want help than those with no current distress. Women were more likely to want help (adjusted OR = 1.34, CI = 1.10–1.64), but there were no significant differences with age group (Table 1). There was no significant interaction with age and sex.

The most popular sources of help were talking to family or friends (59%), advice from GP or nurse (34%), relaxation or yoga (29%), talking therapy (29%), and exercise, sport, or hobbies (28%) (Table 2). Treatment preferences changed with current level of distress. Those with mild-to-moderate distress were more likely than those with no current distress to identify talking therapies (OR = 1.34, 95% CI = 1.04 to 1.71) and massage (OR = 2.25, 95% CI = 1.84 to 2.75) as potential sources of help. They were less likely to choose talking to family or friends (OR = 0.61, 95% CI = 0.52 to 0.70) and self-help leaflets or books (OR = 0.50, 95% CI = 0.35 to 0.70).

Those with severe distress were more likely than those with no current distress to identify talking therapies (OR = 3.43, 95% CI = 2.85 to 4.14), taking

Table 1. Help-seeking preferences by age, sex and current psychological distress.

Covariate	Help-seeking preferences: 'Like some help' *n* (%)	'Deal on own' or 'unsure' *n* (%)	OR (95% CI)[a]
GHQ score (*n* = 1326)			
No distress (0–2)	298 (42.2)	408 (57.8)	1.0
Mild-to-moderate distress (3–6)	163 (48.2)	175 (51.8)	1.27 (1.07 to 1.50)
Moderate-to-severe distress (≥7)	160 (56.7)	122 (43.3)	1.78 (1.40 to 2.28)
Sex (*n* = 1309)			
Male	171 (41.8)	238 (58.2)	1.0
Female	442 (49.1)	458 (50.9)	1.34 (1.10 to 1.63)
Age group, years (*n* = 1293)			
18–29	171 (45.4)	206 (54.6)	1.0
30–39	163 (48.7)	172 (51.3)	1.09 (0.80 to 1.47)
40–49	107 (49.5)	109 (50.5)	1.14 (0.78 to 1.66)
50–59	63 (41.7)	88 (58.3)	0.83 (0.65 to 1.06)
≥60	103 (48.1)	111 (51.9)	1.13 (0.96 to 1.32)

[a]*Odds ratio (OR) for help-seeking preferences, mutually adjusted for GHQ score, sex, and age group, and for clustering by GP practice using robust standard errors, from adjusted Wald test for overall significance of factor in the model. GHQ = General Health Questionnaire.*

tablets (OR = 3.07, 95% CI = 2.00 to 4.71), support groups (OR = 3.07 95% CI = 1.72 to 5.47), massage (OR = 1.80, 95% CI = 1.49 to 2.17), and herbal or homeopathic medicine (OR = 1.30, 95% CI = 1.12 to 1.50) as potentially helpful. They were also much less likely to identify talking to family or friends (OR = 0.33, 95% CI = 0.25 to 0.45), as a source of help. There were no significant differences in preferences for other sources of help. Only 6% of the sample identified no source of help at all. This suggests that many in the 42% who had initially stated that they would prefer to 'deal with it on their own' would not exclude some potential options such as using exercise or relaxation.

DISCUSSION

Summary of main findings

This study found that many people attending their GP would prefer not to seek professional help for emotional distress. Although less than half of the participants reported that they would actively like help if they were feeling 'stressed, worried, or low', almost all people currently experiencing psychological distress identified some form of preferred help. Informal help such as friends or family were more favoured than health professionals, particularly by those not currently distressed.

More physical forms of alternative help such as yoga, exercise, or massage were popular. Formal self-help strategies, such as bibliotherapy or internet-based interventions involving people administering their own treatment, were not nearly as popular as is sometimes presumed, particularly for those with mild-to-moderate distress, which is the likely 'target group' for this form of intervention. Most preferred forms of help involved some form of human contact. Those with mild-to-moderate distress showed stronger preferences for simple measures such as talking to friends and family, advice from their GP, and exercise, relaxation, or massage, than for more formal professional interventions. This is appropriate, as many are likely to have transient and self-limiting distress, and the evidence for

Table 2. Sources of preferred help and association with current psychological distress.

Type of help[a]	Total, *n* = 1357 (%)	Not distressed: GHQ score, 0–2, *n* = 725 (53.4%)	Mild-to moderate distress: GHQ score, 3–6, *n* = 343 (25.3%)	OR[b] (95% CI)	Moderate-to-severe distress: GHQ score ≥7, *n* = 289 (21.3%)	OR[b] (95% CI)
Professional source help[a], these included:						
Advice from GP or nurse	457 (33.7)	240 (33.1)	114 (33.2)	1.02 (0.86 to 1.21)	103 (35.6)	1.20 (0.87 to 1.66)
Talking therapy	388 (28.6)	156 (21.5)	91 (26.5)	1.34 (1.04 to 1.71)	141 (48.8)	3.43 (2.85 to 4.14)
Tablets from your doctor	146 (10.8)	57 (7.9)	32 (9.3)	1.22 (0.95 to 1.57)	57 (19.7)	3.07 (2.00 to 4.71)
Alternative source help[a], these included:						
Talk to family or friend	795 (58.6)	484 (66.8)	193 (56.3)	0.61 (0.52 to 0.70)	118 (40.8)	0.33 (0.25 to 0.45)
Relaxation exercises or yoga	390 (28.7)	201 (27.7)	106 (30.9)	1.08 (0.88 to 1.33)	83 (28.7)	0.93 (0.67 to 1.29)
Exercise, sport, or hobby	371 (27.3)	195 (26.9)	100 (29.2)	1.09 (0.81 to 1.46)	76 (26.3)	0.85 (0.61 to 1.19)
Massage or aromatherapy	299 (22.0)	113 (15.6)	103 (30.0)	2.25 (1.84 to 2.75)	83 (28.7)	1.80 (1.49 to 2.17)
Religious or spiritual support	150 (11.1)	75 (10.3)	43 (12.5)	1.22 (0.85 to 1.76)	32 (11.1)	1.04 (0.70 to 1.55)
Herbal/homeopathic medicine	140 (10.3)	68 (9.4)	34 (9.9)	0.96 (0.61 to 1.52)	38 (13.2)	1.30 (1.12 to 1.50)
Self-help — leaflet or book	102 (7.5)	60 (8.3)	16 (4.7)	0.50 (0.35 to 0.70)	26 (9.0)	1.09 (0.72 to 1.64)
Self-help — internet/computer	70 (5.2)	35 (4.8)	19 (5.5)	1.21 (0.68 to 2.18)	16 (5.5)	1.20 (0.76 to 1.93)
Support group	52 (3.8)	22 (3.0)	6 (1.8)	0.59 (0.15 to 2.27)	24 (8.3)	3.07 (1.72 to 5.47)
No source help identified	82 (6.0)	50 (6.9)	24 (7.0)	1.06 (0.54 to 2.09)	8 (2.7)	0.44 (0.23 to 0.84)

[a]*Multiple responses allowed.* [b]*Odds ratio (OR) for help-seeking compared with 'Not distressed' group, adjusted for age group and sex and for clustering by GP practice, from adjusted Wald test for overall significance of factor in the model. GHQ = General Health Questionnaire.*

effectiveness of interventions in such cases is limited. People who were severely distressed were more likely to consider medication as an option, but talking to someone was still the most popular form of help identified. The more distressed a person was, the more likely they were to value professional talking therapies, and less likely to want to talk to friends and family.

Strengths and the limitations of the study

This study is limited by its cross-sectional nature and its focus on perceived preferences rather than actual behaviours. A deliberate decision was taken to ask a hypothetical question about people's likely actions if they were feeling distressed, to reduce social desirability bias in their responses, and to enable an interpretation in the light of their current level of distress. For practical reasons, those unable to complete a questionnaire in English were excluded, and the results do not therefore apply to this population. The results come from a large sample recruited across seven urban or suburban GP practices and, unlike the previous community surveys,[12,13] there was a very high response rate. The results demonstrate that a representative sample of GP attenders would like help from a wide range of different sources and that these vary according to the level of distress currently experienced. This study may not reflect the views of those who do not attend their GP, who might show stronger preferences for informal, alternative, self-help or voluntary sector sources of help, and may not represent those living in more rural areas.

Comparison with existing literature

Despite high-profile public education campaigns,[15,16] many people attending their GP or practice nurse report that they would not seek professional help for emotional distress. This is consistent with previous work from population surveys, showing few people actively seek help for anxiety and depression, even when they have quite high levels of psychiatric symptoms.[7,8] Patient participation in decision making has been found to be a key factor for improving treatment adherence and clinical outcome in depression,[17] and treatment preferences are likely to play a role in decisions to seek and take up offers of treatment or help.

There is limited evidence on effective interventions for milder degrees of distress in primary care.[2,3] Current guidance suggests watchful waiting, exercise, and guided self-help as possible strategies for mild depression.[2] The present study showed that less than one-third of those with milder distress expressed a preference for exercise as a form of help. Despite recent interest in making these more widely available,[18,19] written self-help interventions delivered using leaflets or books or the internet were not popular at any level of distress. This might be due to lack of knowledge or unclear expectations of these approaches,[20] and may only apply to self-administered, as opposed to 'guided' self-help facilitated by a professional, where there is a stronger evidence base for effectiveness.[2]

The results of this study indicate that at higher levels of distress, the desire for professional talking therapies or tablets increases, and the wish to talk to family or friends decreases, a finding that is consistent with previous work.[8,12,21] This may be due to a variety of reasons, including the more severely distressed finding it harder to talk to friends or family than expected, being more socially isolated, or fear of overburdening their friends or family. It is also possible that, having tried approaching personal contacts and found it unhelpful, some people may feel that only a professional can help. While nearly half of the more-severely distressed group expressed a preference for talking therapies, this does not necessarily translate into help-seeking behaviours, as the literature shows that many in this group do not actively seek or receive this help.[7,8]

Implications for future research and practice

In this study, informal help was preferred over professional support, particularly for those with few or no current symptoms of distress. Most forms of preferred help involved some form of human contact, which has implications for the widespread application of self-help for milder distress in primary care. The study supports guidelines and previous research suggesting that formal interventions, such as talking therapies or medication should be reserved for more severe disorders. Further research is needed on the likely uptake and effectiveness in a real-life primary care context of any possible interventions for milder distress, before any widespread implementation occurs.

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Ethical approval

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Competing interests

The authors have stated that there are none

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REFERENCES

1. Double D. The limits of psychiatry. *BMJ* 2004; **324(7342):** 900–904.
2. National Institute for Clinical Excellence. *Depression: management of depression in primary and secondary care. NICE guidance December 2004, revised May 2007.* London: National Institute for Clinical Excellence. http://www.nice.org.uk/CG023 (accessed 14 Jul 2008).
3. Kirsch I, Deacon BJ, Huedo-Medina TB, *et al.* Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration. *PLoS Med* 2008; **5(2):** e45.
4. WHO World Mental Health Survey Consortium. Prevalence, severity and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA* 2004; **291(21):** 2581–2590.
5. Wang PS, Lane M, Olfson M, *et al.* Twelve-month use of mental health services in the United States: results from the National Co-morbidity Survey Replication. *Arch Gen Psychiatry* 2005; **62:** 629–640.
6. Simon GE, Fleck M, Lucas R, Bushnell DM and the LIDO group. Prevalence and predictors of depression treatment in an international primary care study. *Am J Psychiatry* 2004; **161(9):** 1626–1634.
7. Roness A, Mykletun A, Dahl AA. Help-seeking behaviour in patients with anxiety disorder and depression. *Acta Psychiatr Scand* 2005; **111(1):** 51–58.
8. Bebbington P, Meltzer H, Brugha TS, *et al.* Unequal access and unmet need: neurotic disorders and the use of primary care services. *Psychol Med* 2000; **30(6):** 1359–1367.
9. Dwight-Johnson M, Meredith LS, Hickey SC, Wells KB. Influence of patient preference and primary care proclivity for watchful waiting on receipt of depression treatment. *Gen Hosp Psychiatry* 2006; **28(5):** 379–386.
10. Dwight-Johnson M, Sherbourne CD, Liao D, Wells KB. Treatment preferences among depressed primary care patients. *J Gen Intern Med* 2000; **15(8):** 527–534.
11. Brody DS, Khaliq AA, Thompson TL. Patients' perspectives on the management of emotional distress in primary care settings. *J Gen Intern Med* 1997; **12(7):** 403–406.
12. Jorm AF, Griffiths KM, Christensen H, *et al.* Actions taken to cope with depression at different levels of severity: a community survey. *Psychol Med* 2004; **34(2):** 293–299.
13. Kessler RC, Soukup J, Davis RB, *et al.* The use of complementary and alternative therapies to treat anxiety and depression in the United States. *Am J Psychiatry* 2001; **158(2):** 289–294.
14. Goldberg D, Williams D. *A user's guide to the General Health Questionnaire.* Windsor: NFER Nelson, 1988.
15. Paykel ES, Hart D, Preist RG. Changes in public attitudes to depression during the Defeat Depression Campaign. *Br J Psychiatry* 1998; **173:** 519–522.
16. Hirschfeld RM, Keller MB, Panico, *et al.* The National Depressive and Manic-Depressive Association consensus statement on the under-treatment of depression. *JAMA* 1997; **277(4):** 333–340.
17. Loh A, Leonhart R, Wills CE, *et al.* The impact of patient participation on adherence and clinical outcome in primary care of depression. *Patient Educ Couns* 2007; **65(1):** 69–78.
18. Jorm AF, Griffiths KM. Population promotion of informal self-help strategies for early intervention against depression and anxiety. *Psychol Med* 2006; **36(1):** 3–6.
19. Kaltenhaler E, Brazier J, De-Nigris E, *et al.* Computerised cognitive behavioural therapy for depression and anxiety update: a systematic review and economic evaluation. *Health Technol Assess* 2006; **10(33):** iii, xi–xiv: 1–168.
20. Macdonald W, Mead N, Bower P, *et al.* A qualitative study of patients' perceptions of a 'minimal' psychological therapy. *Int J Social Psychiatry* 2007; **53(1):** 23–35.
21. Jorm AF, Christensen H, Medway J, *et al.* Public belief systems about the helpfulness of interventions for depression: associations with history of depression and professional help-seeking. *Soc Psychiatry Psychiatr Epidemiol* 2000; **35(5):** 211–219.